BUDGET AND PERFORMANCE REQUIREMENTS

Fiscal Year 2005

June 24, 2004

Medicare Integrity Program

CARRIER BPRs

Program Management

Medicare Integrity Program

FY 2005 BUDGET AND PERFORMANCE REQUIREMENTS

General Instructions (All Contractors)

I. GENERAL DIRECTIONS

General instructions for the preparation of the Budget Request (BR) are contained in the Centers for Medicare & Medicaid Services' (CMS) Medicare Financial Management Manuals, Chapter 1. Contractors should use the instructions in the manual when preparing their BR in the Contractor Administrative-Budget and Financial Management System (CAFM II). These Budget and Performance Requirements (BPRs) and the Medicare Financial Management Manual specify all forms and accompanying budget documentation narrative that constitute the BR.

Send the BR to the Regional Office (RO) no later than August 5, 2004. *Send 3 informational copies of the budget package to Central Office at the following address:*

Centers for Medicare & Medicaid Services
Office of Financial Management
Division of Contractor Budget Management
7500 Security Boulevard
Mailstop C3-13-06
Baltimore, Maryland 21244

Note: Do not mail a hardcopy of anything that was inputted into CAFM II.

II. MEDICARE CONTRACTOR TRANSITIONS TO THE HEALTHCARE INTEGRATED GENERAL LEDGER ACCOUNTING SYSTEM (HIGLAS)

The transition of Medicare contract workloads to HIGLAS will begin in Fiscal Year 2005. The transitions will occur in two waves (see below). Contractors are not to include any estimates in their Budget Request (BR) for the anticipated HIGLAS transition costs. Separate instructions will be provided for requesting and receiving this funding. Transition activities would as a minimum include project management, connectivity, job mapping, training, testing, data conversion, cutover, and post transition support.

Wave 1 Implementations:

Empire Medicare Services - Intermediary Contract (Contractor #308)

First Coast Service Options - Intermediary Contract (Contractor #90)

Trailblazer Health Enterprises - Intermediary Contract (Contractor #400)

Mutual of Omaha Insurance Company - Intermediary Contract (Contractor #52280)

Wave 2 Implementations:

First Coast Service Options - Carrier Contract (Contractor #590)

Cahaba Government Benefit Administrators - Intermediary Contract (Contractor #10)

United Government Services - Intermediary Contract (Contractor #450/452)

Anthem Insurance Companies - Intermediary Contract (Contractor #130)

III. INTERNAL CONTROLS

Contractors are required to have adequate internal controls in place, as stated in their contracts with the Government. In the contract, they agree to cooperate with CMS in the development of procedures to ensure compliance with the Federal Managers Financial Integrity Act (FMFIA). The Comptroller General of the United States prescribes the standards to be followed in order to be in compliance with the intent of FMFIA.

The ultimate responsibility for sound internal controls rests with contractor management. Internal controls should not be looked upon as separate, specialized systems within an organization. Rather, they should be recognized as an integral part of each system that management uses to regulate and guide its operations. Internal controls facilitate the achievement of management objectives by serving as checks and balances. A good internal control system includes a risk assessment, proper documentation, and testing of that system. It is expected that each contractor have adequate internal controls to accomplish its operations.

Contractors are required to certify compliance with FMFIA by providing assurances that controls are in place and operating effectively by having written policies and procedures for these controls. The contractors are responsible for correcting any internal control material weaknesses identified though the annual self-certification process or other oversight reviews. This requirement is essential to the certification of CMS' financial statements by the Office of Inspector General and to provide CMS with knowledge and assurances that contractor operations are complying with CMS instructions and directions. Specific instructions regarding internal control requirements and the annual self-certification process are available in Pub. 100-6, the Financial Management Manual in Chapter 7, Internal Controls.

IV. CONTRACTOR BUDGET FLEXIBILITY

Contractor budget flexibility refers to each contractor's authority to shift funds within its Notice of Budget Approval (NOBA) once issued. The passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes the establishment of the Medicare Integrity Program (MIP). Section 202 of the Act identifies those functions to be funded through MIP and provides separately appropriated funds for them. The remaining contractor functions will be funded through our Program Management budget.

Program Management (PM)

Contractors may shift funds between PM functions in the NOBA. However, the cumulative amounts shifted to or from any PM function may not exceed 5 percent of the largest approved amount for that function. This flexibility is consistent with the provisions contained in the current intermediary and carrier contracts.

The following are PM functions:

- Bills/Claims Payment (Intermediary and Carrier);
- Provider/Supplier Enrollment (Intermediary and Carrier);
- Appeals/Hearings (Intermediary and Carrier);
- Beneficiary Inquiries (Intermediary and Carrier);
- Provider Inquiries (Intermediary and Carrier);
- PM-Provider Communications (Intermediary and Carrier);
- Participating Physician (Carrier); and
- Provider Reimbursement (Intermediary).

Productivity Investments (PI): No more than 5 percent may be shifted into or out of PI treated as a whole rather than by separate project.

Special Projects (SP): No more than 5 percent may be shifted into or out of SP treated as a whole rather than by separate project.

Medicare Integrity Program (MIP)

Only the RO Budget and Program Integrity staffs may negotiate with the contractor concerning the amount and distribution of MIP funding. RO staff must notify CO immediately, should the contractor wish to negotiate a significant increase or decrease in funding and workload.

Contractors may shift funds between MIP functions in the NOBA. However, the cumulative amounts shifted to or from any MIP function may not exceed 5 percent of the largest approved amount for that function. This flexibility is consistent with the provisions contained in the current intermediary and carrier contracts.

The following are MIP functions:

- Medical Review and Utilization Review (Intermediary and Carrier);
- Medicare Secondary Payer - Prepayment (Intermediary and Carrier);
- Benefit Integrity (Intermediary and Carrier);
- Local Provider Education and Training (Intermediary and Carrier);
- Provider Communications (Intermediary and Carrier); and
- Audit (Intermediary); and
- Medicare Secondary Payer - Postpayment (Intermediary and Carrier).

Productivity Investments (PI): No more than 5 percent may be shifted into or out of PI treated as a whole rather than by separate project.

Special Projects (SP): No more than 5 percent may be shifted into or out of SP treated as a whole rather than by separate project.

Other Budget Flexibility Constraints

- Funding governed by contract modifications may not be shifted.

- The PM and MIP funding represent totally segregated funds which shall not be commingled by the Government or the contractors. Therefore, there is NO flexibility to shift funds between the PM and MIP funds provided. Contractors shall receive separate funding distributions for PM and MIP activities and shall report costs consistent with their budgets, separately identifying PM and MIP activity costs. Funds will continue to be separately accounted for by contractors on the Interim Expenditure Reports (IER) and Final Administrative Cost Proposal (FACP) and funds will be separately disbursed through the Payment Management System.

V. ADHERENCE TO PERFORMANCE REQUIREMENTS

Contractors are required to adhere to all specific performance requirements stated in these instructions and to explicitly demonstrate compliance with all requirements within any targeted funding levels. Accordingly, all contractors shall include in their requests, the workload and costs associated with each activity stated in the requirements. The requests shall include an explanation and justification for the costs and workload. This information is required even if the information is not specifically requested on the schedule attachments.

> *Note: Do not acquire, or obligate to acquire, additional resources to meet any new requirements as stated in these BPRs, until a Program Memorandum or manual issuance providing instructions is issued and until funding has been approved.*

You must fully justify each function of the BR. Include the following:

- Justify funding based on the performance requirements stated in the BPRs, but DO NOT restate the BPRs requirements.

- If the performance requirements have not changed from FY 2004, explain how the performance goals will be achieved within currently available funding limits, if applicable.

- If the performance requirements have changed, clearly document and justify any funding change (up or down) associated with the change.

If you comply with the BPRs statement of workload and level of effort, you must include a statement that clearly states compliance with the BPRs. Otherwise, you must state reasons for non-compliance, if applicable.

VI. NARRATIVE AND FINANCIAL ANALYSIS REQUIREMENTS

Include a narrative analysis (budget justification) that summarizes the funding and workload requested for each function. The analysis shall provide information as indicated below, in addition to any specific information requested in the separate sections for each operation. Operations personnel should actively participate in the development of the BR.

A. WORKLOADS:

- If CMS workload volumes are supplied and those volumes are acceptable, no volume analysis is required.

- Requests for changes in workload from any CMS provided volumes must be supported by a volume analysis that includes the historical data used to make the projection, a description of the forecast methodology used, and the actual forecast computation. This applies to all activities with identifiable workload volumes.

B. FUNCTION REQUIREMENTS:

- Include any additional information specifically requested in the functional areas of the BPRs.

- Identify and discuss, in total and by function, any material amounts included in the BR that relate to costs of or changes to:

    - Pension plans, including non-qualified plans, as defined by Financial Accounting Standards Board Statement (SFAS) 87/88 (Employers' Accounting for Pensions/Employers' Accounting for Settlements and Curtailments of Defined Benefit Pension Plans and for Termination Benefits) and;

    - Post-Retirement benefit plans as defined by SFAS 106 (Employers' Accounting for Post-Retirement Benefits Other than Pensions). Post-retirement benefit plans include retiree health benefits provided by separate Internal Revenue Code (IRC) 401(h) accounts within a qualified pension trust.

    These costs are to be allocated to EACH function/activity in your BR and not separately grouped as a PI or Special Project cost.

You must bear the following points in mind as regards the allocation of such costs to the Medicare contract/agreement (see FAR 31.205-6(j), 31.205-6(o), 31.205-19, 28.307-1 and 28.308):

- In order for such pension and/or post-retirement benefit costs to be allowable, they must be <u>funded.</u>

- Any change in accounting practice for such pension and/or post-retirement benefit costs must be submitted to CMS in advance for approval.

    - Changes in accounting practice include, but are not limited to: a change from cash (pay-as-you-go) accounting to accrual accounting, a change from accrual accounting to cash accounting, a change in actuarial cost method, a change on actuarial asset valuation method, or a change in amortization periods or policy.

- Pension costs are only assignable, and thereby allocable and allowable, if the transition provisions of Cost Accounting Standards (CAS) 412-64 are met and the pension plan is in actuarial balance in accordance with CAS 412-40(c).

- If accrual accounting is elected, the amount of allowable cost for post-retirement benefit plans is limited to the total cost determined when the "Transition Obligation" is computed and amortized according to paragraphs 112 and 113 of SFAS 106.

- If the costs of employee insurance programs or post-retirement benefits are based on the premiums or other charge for an insurance program maintained by or under the control of the contractor:

    - The program must be submitted to CMS in advance for approval. A copy of the plan and the underlying actuarial basis for determining the costs or reserves shall be included with your BR.

    - Thereafter, a schedule developing the annual and cumulative loss ratio based on the claims paid, premiums received, expenses, and reserve or retention charges on an annual and cumulative basis should be retained.

    - Separately identify the insurance program from the remainder of your BR.

    Reminder: For each defined-benefit pension plan or post-retirement benefit plan for which accrual accounting is used to determine pension costs, supporting documentation for the FACP must be maintained until such pension or post-retirement costs are audited and closed. Also, a record by individual participant of the actuarial liability (accumulated postretirement benefit obligation), normal cost (service cost), cost center and other appropriate census data must be maintained until such pension or post-retirement costs are audited and closed.

    - The actuarial liability (accumulated postretirement benefit obligation) and normal cost (service cost) in the individual participant records must be the values used for determining the cost charged to the FACP and might differ from the amounts used for IRS or financial statement purposes**.**

    - Additionally, the individual actuarial liability determined under the accrued benefit cost method, also known as the unit credit method without projection, should be maintained for defined-benefit pension plans.

C. EXECUTIVE COMPENSATION:

Beginning with 1997, allowable compensation to executives has been limited for purposes of determining government contract costs under the authority of Section 809 of Public Law 104-201. Compensation is defined as "total amount of wages, salary, bonuses, deferred compensation, and employer contributions to defined contribution pension plans."

For FY 2004, the statutory provision increased the limit to $432,851 (it was $405,273 for FY 2003, $387,783 for FY 2002, $374,228 for FY 2001, $353,010 for FY 2000, $342,986 for FY 1999, $340,650 for FY 1998 and $250,000 for FY 1997 per year. This amount is the maximum allowable compensation of the 5 highest paid executives at the home office and at each segment of the organization, whether or not the home office or segment reports directly to the contractor's headquarters. This limitation amount applies to contract costs incurred after January 1, 2004.

This $432,851 cap applies to total taxable wages plus elective deferrals before any allocations are applied. For example, if the CEO of ABC company earns an annual salary of $600,000, and the allocation to the Medicare segment is 30%, only $432,851of the total $600,000 is considered allowable and $129,855 (30% of $432,851) is allocable to Medicare.

Beginning in FY 1998, the cap was made permanent by Section 808 of Public Law 105-85. The Administrator of the OFPP sets the ceiling for the allowable amount of executive compensation for 1999, and each succeeding FY (including deferred compensation awards and contributions to defined contribution, e.g., 401(k), pension plans).

On March 4, 1999, the Civilian Agency Acquisition Council and the Defense Acquisition Regulations Council issued an interim rule to broaden the definition of "senior executive" found at FAR 31.205-6(p), to clearly include the five most highly compensated employees in management positions at each home office and each segment of the contractor <u>whether or not the home office or segment reports directly to the contractor's headquarters.</u> The interim rule applies to costs of compensation incurred after January 1, 1999, regardless of the date of contract award.

D. GENERAL REQUIREMENTS:

Contractor standard budget and cost accounting methodologies used to develop the BR shall be described and used in your narrative if requested by CMS.

It is the responsibility of the contractor to fully document and justify the level of funding required for each function and to document compliance with the BPRs. Failure to do so could result in funding not being provided. <u>DO NOT</u> assume from the above that funding will be provided at the current Notice of Budget Approval (NOBA) level. Be prepared to discuss all functions during discussions with the RO.

E. CMS RO DISCRETION ON DOCUMENTATION NEEDED WITH BR.

The RO has considerable discretion to change the BR documentation requirements for PM activities. CAFM II documents must be transmitted in ALL cases. Also the items listed in

Section VII must be included with the BR submission. Please contact your RO for instructions on what information they will require with the BR submission.

F. PRODUCTIVITY INVESTMENT (PI)/"SPECIAL PROJECT" (SP) COSTS:

Any funds requested for PI and SP costs must be fully explained unless they conform to a contract modification, such as for Common Working File Host and Maintenance contracts. Cost-benefit ratios, implementation timeframes, and the impact on the Medicare operations shall be discussed as appropriate.

VII. ELECTRONIC AND HARD COPY SUBMISSION OF BUDGET REQUESTS

All contractors shall submit their initial FY 2005 BRs, to CMS' mainframe computer, no later August 5, 2004, using CAFM II. Instructions for transmission are contained in the User's Manual.

DO NOT mail a hardcopy of ANYTHING that was inputted into CAFM II.

Note: The BR mailed to the RO, and the 3 informational copies that are to be mailed to the CO, should include the contractor number and name on the upper right hand corner of each page. To expedite the breakdown of the BR by RO/CO component, please insert a Page Break between each section.

Forms transmitted on CAFM II and CASR include:

Activity Forms (With the following attachments as required by CMS):

- Miscellaneous Schedule
- Special Projects Schedule (if applicable)
- Certification Schedule Cost Classification Report - CMS-2580
- Contractor Auditing and Settlement Report (A) - CMS-1525A
- Provider Reimbursement Profile (A) - CMS-1531
- Schedule of Providers Serviced (A) - CMS-1531A

The following MUST be included with your hardcopy BR submission:

- Financial Information Survey (See General Instructions, Section XX)
- Revisions to your Appeals Quality Improvement/Data Analysis Plan (See Appeals)
- Customer Service Plan (See Beneficiary Inquiries)
- Provider/Supplier Service Plan (See MIP-PCOM)
- Medical Review (MR)/Local Provider Education and Training (LPET) - Strategy Report/Quality Improvement Program Plan (See MR and LPET)
- Benefit Integrity (BI) - Supporting Documentation (See BI) (Carriers Only)

NOTES:

1. The Cost Classification Schedule is only required with the initial BR. For the BR, the schedule includes the Return on Investment information.

2. Include cost/benefit documentation for Productivity Investments as appropriate with the hardcopy submission.

3. Contractors have been provided with an EXCEL file for the requested audit information. This EXCEL file should be sent electronically to your RO and Dave Czerski (dczerski@cms.hhs.gov) in the CO.

4. Contractors should send an electronic version of the MR/LPET Strategy Report and the Quality Improvement Program Plan your RO. Contractors shall negotiate the MR/LPET Strategy with your RO. The final MR/LPET Strategy should be sent to MRSTRATEGIES@cms.hhs.gov.

5. Contractors should send an electronic version of any revisions to your Appeals Quality Improvement/Data Analysis Plan to AppealsOperations@cms.hhs.gov and your RO.

6. Contractors should send a draft or preliminary copy of the Provider/Supplier Service Plan (PSP) to your RO PSP coordinator or contact, for review at the time you submit your BR. The final PSP will be due on October 31, 2004.

7. The following is the core listing of required CAFM II Activity Codes to be used in completing your BR:

INTERMEDIARIES

Program Management

Activity Code	Description
11201	Perform EDI Oversight
11202	Manage Paper Bills/Claims
11203	Manage EDI Bills/Claims
11204	Bills/Claims Determination
11205	Run Systems
11206	Manage Information Systems Security Program
11207	Perform COB Activities with the COBC, Supplemental Payers and States
11208	Conduct Quality Assurance
11209	Manage Outgoing Mail
11210	Reopen Bills/Claims
12090	Quality Improvement/Data Analysis
12110	Part A Reconsiderations/Redeterminations

12113	Incomplete Reconsideration/Redetermination Requests
12120	Part A ALJ Hearing Requests
12141	Part B Telephone Reviews/Redeterminations
12142	Part B Written Reviews/Redeterminations
12143	Part B Incomplete Review/Redeterminaton Requests
12150	Part B Hearing Officer Hearings
12160	Part B ALJ Hearings
12901	PM CERT Support
13002	Beneficiary Written Inquiries
13004	Customer Service Plan
13005	Beneficiary Telephone Inquiries
13201	Second Level Screening of Beneficiary and Provider Inquiries
14101	Provider/Supplier Information and Education Website
14102	Electronic Mailing Lists (Listservs)
16002	Non-MSP Debt Collection/Referral
16003	Interim Payment Control
16004	Reimbursement Report and File Maintenance
16005	Provider-Based Regulations
31001	Provider/Supplier Enrollment Ongoing
33001	Answering Provider Telephone Inquiries
33002	Provider Written Inquiries
33003	Provider Walk-In Inquiries
33014	QCM Performance Measures
33020	Staff Development and Training

Medicare Integrity Program

Activity Code	Description
21001	Automated Review
21002	Routine Reviews
21007	Data Analysis
21010	Third Party Liability (TPL) or Demand Bills
21206	Policy Reconsideration/Revision
21207	MR Program Management
21208	New Policy Development
21220	Complex Probe Review
21221	Prepay Complex Review
21222	Postpay Complex Review
21901	MIP CERT Support

22001	MSP Bills/Claims Prepayment
22005	MSP Hospital Audits/On-Site Reviews
23201	PSC Support Services
23001	Medicare Fraud Information Specialist (MFIS)
23004	Outreach and Training
23005	Fraud Investigation
23006	Law Enforcement Support
23007	Medical Review in Support of Benefit Integrity
23014	FID Entries
23015	Referrals to Law Enforcement
24116	One-on-One Provider Education
24117	Education Delivered to a Group of Providers
24118	Education Delivered via Electronic or Paper Media
25103	Create/Produce and Maintain Educational Bulletins
25105	Partner With External Entities
25201	Administration and Management of PCOM Program
25202	Develop Provider Education Materials and Information
25203	Disseminate Provider Information
25204	Management and Operation of PCOM Advisory Group
26001	Provider Desk Reviews
26002	Provider Audits
26003	Provider Settlements
26004	Cost Report Reopenings
26005	Wage Index Review
26011	PRRB and Intermediary Hearings
42002	Liability, No-Fault, Workers' Compensation
42003	Group Health Plan
42004	General Inquiries
42021	Debt Collection/Referral

Misc. Code	Description
12120/01	Part A ALJ Courier Service
12141/01	Part B Telephone Review/Redetermination Dismissals and Withdrawals
12142/01	Part B Written Review/Redetermination Dismissals and Withdrawals of Review Requests
12160/01	Part B ALJ Courier Service
13005/01	Beneficiary Inquiries NGD Implementation Costs
13201/01	Second Level Screening of Provider Inquiries

23007/01	Use of Extrapolation - Number of Consent Settlements Offered
23007/02	Use of Extrapolation - Number of Consent Settlements Accepted
23007/03	Use of Extrapolation - Number of Statistical Sampling performed for Overpayment Estimation
23201/01	PSC Support Services - Miscellaneous PSC Support Services
23201/02	PSC Support Services - Non-Law Enforcement Investigation Requests
23201/03	PSC Support Services - Law Enforcement Requests
25202/01	Special Media Creation
33001/01	Provider Inquiries NGD Implementation Costs
51020/01-51020/18	Data Center Costs
51020/01	Adminastar Federal Inc.
51020/03	BCBS Alabama
51020/04	BCBS Arkansas
51020/05	BCBS Kansas
51020/06	CIGNA
51020/07	EDS - Plano
51020/08	EDS - Sacramento
51020/09	Empire BCBS
51020/10	First Coast Service Options
51020/12	GTE Data Services
51020/13	Highmark
51020/14	Mutual of Omaha
51020/15	Palmetto (aka BCBS South Carolina)
51020/16	Regence BCBS Oregon

CARRIERS

Program Management

Activity Code	Description
11201	Perform EDI Oversight
11202	Manage Paper Bills/Claims
11203	Manage EDI Bills/Claims
11204	Bills/Claims Determination
11205	Run Systems
11206	Manage Information Systems Security Program
11207	Perform COB Activities with the COBC, Supplemental Payers and States
11208	Conduct Quality Assurance
11209	Manage Outgoing Mail

11210	Reopen Bills/Claims
11211	Non-MSP Carrier Debt Collection/Referral
12090	Quality Improvement/Data Analysis
12141	Part B Telephone Reviews/Redeterminations
12142	Part B Written Reviews/Redeterminations
12143	Part B Incomplete Review/Redetermination Requests
12150	Part B Hearing Officer Hearings
12160	Part B ALJ Hearings
12901	PM CERT Support
13002	Beneficiary Written Inquiries
13004	Customer Service Plan
13005	Beneficiary Telephone Inquiries
13201	Second Level Screening of Beneficiary and Provider Inquiries
14101	Provider/Supplier Information and Education Website
14102	Electronic Mailing Lists (Listservs)
15001	Participating Physicians
31001	Provider/Supplier Enrollment Ongoing
33001	Answering Provider Telephone Inquiries
33002	Provider Written Inquiries
33003	Provider Walk-In Inquiries
33014	QCM Performance Measures
33020	Staff Development and Training

Medicare Integrity Program

Activity Code	Description
21001	Automated Review
21002	Routine Review
21007	Data Analysis
21206	Policy Reconsideration/Revision
21207	MR Program Management
21208	New Policy Development
21220	Complex Probe Review
21221	Prepay Complex Review
21222	Postpay Complex Review
21901	MIP CERT Support
22001	MSP Bills/Claims Prepayment

23001	Medicare Fraud Information Specialist (MFIS)
23004	Outreach and Training
23005	Fraud Investigation
23006	Law Enforcement Support
23007	Medical Review in Support of Benefit Integrity
23014	FID Entries
23015	Referrals to Law Enforcement
23201	PSC Support Services
24116	One-on-One Provider Education
24117	Education Delivered to a Group of Providers
24118	Education Delivered via Electronic or Paper Media
25103	Create/Produce and Maintain Educational Bulletins
25105	Partner with External Entities
25201	Administration and Management of PCOM Program
25202	Develop Provider Education Materials and Information
25203	Disseminate Provider Information
25204	Management and Operation of PCOM Advisory Group
42002	Liability, No-Fault, Workers' Compensation
42003	Group Health Plan
42004	General Inquiries
42021	Debt Collection/Referral

Misc Code	Description
11208/01	Part B Quality Assurance Reviews
12141/01	Part B Telephone Review/Rederterminaion Dismissals and Withdrawals
12142/01	Part B Written Review/Redetermination Dismissals and Withdrawals
12160/01	Part B ALJ Courier Service
13005/01	Beneficiary Inquiries NGD Implementation
13201/01	Second Level Screening of Provider Inquiries
21222/01	Advance Determinations of Medicare Coverage
23007/01	Use of Extrapolation - Number of Consent Settlements Offered
23007/02	Use of Extrapolation - Number of Consent Settlements Accepted
23007/03	Use of Extrapolation - Number of Statistical Sampling performed for Overpayment Estimation
23201/01	PSC Support Services - Miscellaneous PSC Support Services

23201/02	PSC Support Services - Non-Law Enforcement Investigation Requests
23201/03	PSC Support Services - Law Enforcement Requests
25202/01	Special Media Creation
33001/02	Provider Inquiries NGD Implementation
51020/01-51020/18	Data Center Costs
51020/01	Adminastar Federal Inc.
51020/03	BCBS Alabama
51020/04	BCBS Arkansas
51020/05	BCBS Kansas
51020/06	CIGNA
51020/07	EDS - Plano
51020/08	EDS - Sacramento
51020/09	Empire BCBS
51020/10	First Coast Service Options
51020/12	GTE Data Services
51020/13	Highmark
51020/14	Mutual of Omaha
51020/15	Palmetto (aka BCBS South Carolina)
51020/16	Regence BCBS Oregon

5. Use the following codes for transmitting cost data if you are a host contractor:

CWF Host-Ongoing:	Code 11002
UPIN Registry (Host only):	Code 11003

VIII. DURABLE MEDICAL EQUIPMENT REGIONALIZATION CARRIERS (DMERC)

A separate statement of work will be developed for all DMERCs. However, DMERCs must submit BRs on CAFM II consistent with their current scope of work, unless a projected scope of work is available. Cost performance targets will be established through these BPRs consistent with the treatment of all other contractors.

IX. REPORTING CONTRACTOR OVERPAYMENT COSTS

When a potential overpayment is identified, certain steps are normally followed to determine if an overpayment does exist. These steps are referred to as the development process. The functional component completing the development process normally:

- Investigates the claims and associated documentation;
- Does the appropriate research;
- Determines if an overpayment exists and the nature of the overpayment; and

- Creates the contents of the first demand letter.

The costs associated with the development process should be charged to the activity code associated with the functional component completing the development process. Some examples of the functional component include: Medical Review, Benefits Integrity, MSP, Claims Processing, or in limited cases Overpayment staff.

After the overpayment is identified the following additional steps are necessary:

- Issue Demand Letter and/or Initiate Claim Adjustment;
- If necessary, post the claim adjustment;
- Mail the Demand Letter; and
- Post the account receivable.

If the functional component that developed the overpayment completes these additional steps, then the costs associated with them shall be charged to the activity code associated with that functional component. However, another unit, such as Overpayments or Claims Processing, may also complete these steps. If another unit completes these additional steps, the activity code associated with that unit shall be charged for the completion of these steps.

The initiation of the claim adjustment is considered part of the development process and shall be attributed to the activity code associated with the unit completing the development process. The posting of the claim adjustment may be attributed to the development process if a member of the staff completing the development process is also completing the claim adjustment. However, if another unit, such as claims processing is completing the posting of the claim adjustment the cost associated with the posting shall be attributable to the appropriate claim processing activity code.

The remaining steps in the overpayment process generally focus on recovery. These steps may include:

- Posting the overpayment onto the POR/PSOR System;
- Initiating prompt recoupment;
- Extended repayment plan process;
- Verification of bankruptcy information for accuracy and timeliness;
- Referral to the Department of Treasury process; and
- Any other activity associated with the debt collection/referral of the overpayment.

These steps are normally completed by the Overpayments Unit and shall be attributed to the activity codes for Non-MSP Debt Collection/Referral. (Activity Code 16002 for Intermediaries and Activity Code 11211 for Carriers) MSP Post payment debt collection staff may also complete some of the above activities. If MSP Postpayment debt collection staff performs the activities, Activity Code 42021 shall be charged.

The financial accounting and reporting associated with the overpayment recoveries will continue to be handled as an overhead cost. These tasks include (among others), establishing and tracking the accounts receivables, CNC reporting, and the compilation and reporting of financial data

including CMS forms 750 and 751. Such costs represent contractor fiduciary oversight and general accounting processes, and as such, should be treated as overhead and spread across all Activity Codes. (See General Instructions, Section XIX for additional codes associated with the preparation of portions of the financial statement.)

Note: A reopening, which is the regulatory vehicle for reexamining an initial or revised determination that is not otherwise appealable, may or may not result in an overpayment or claim adjustment. Reopening activities include reexamining the claim and any associated documentation or other information to determine whether the previous decision should be revised. Such activities are charged to the reopenings activity code (Activity Code 11210).

If the reopening results in an overpayment the activities described above should be completed.

Any activities associated with credit balance report 838 should be charged to overhead.

CAFM II CODES

Contractors are to report the costs of developing, recovering, and reporting overpayments in the following manner:

Program Management

Intermediaries and carriers are to report all overpayment development costs in the respective budget area from which they were generated.

Intermediaries are to report all debt collection/referral costs in the Reimbursement Activity Code 16002, Non-MSP Debt Collection/Referral.

Carriers are to report all debt collection/referral costs in the Bills/Claims Payment Activity Code 11211, Non-MSP Carrier Debt Collection/Referral.

Medicare Integrity Program

Intermediaries and carriers are to report all overpayment development costs in the respective budget areas from which they were generated.

All non-MSP overpayment debt collection/referral costs are reported as stated in the aforementioned section on Program Management.

All MSP overpayment debt collection/referral costs are reported in the Post payment MSP Activity Code 42021, Debt Collection/Referral.

X. COMPLEMENTARY CREDIT RATES

Coordination of Medicare and Complementary Insurance Programs.

The complementary credit rates for all insurers are determined by the Office of Financial Management (OFM) in accordance with the Social Security Act 1882 (a) Supplemental Insurance Policies; 1842(h)3(B), requirements to share claims data, and the United States Code § 9701, guidelines to set standards for fees.

The FY 2005 rates for all insurers are: Part A $0.69 and Part B $0.54.

XI. CWF HOSTS AND SATELLITES

The current one-year extension to the host site contracts expires on September 30, 2004. Each host site will submit FY 2005 budget requests for host site activities in response to CMS' request to exercise an option for an additional one-year extension to the existing host contracts.

XII. CONTRACTOR TESTING REQUIREMENTS

CMS released Change Request 1462, Program Memorandum AB-01-07, on January 19, 2001. This PM provides guidance on testing responsibility for each organization involved in Medicare fee-for-services quarterly systems releases. A new CMS Change Request 3011 has been written to replace Change Request 1462. It is anticipated that Change Request 3011 will be finalized and issued prior to FY 2005. Intermediaries and carriers are expected to continue to comply with Change Request 1462 or its replacement Change Request 3011 in FY 2005.

XIII. PARTICIPATION IN WORKGROUPS

Intermediaries and carriers are expected to participate in workgroups sanctioned by their respective standard system maintainer change control boards, as well as ad hoc groups formed by CMS. Participation on the ad hoc groups is not mandatory, but discretionary based on contractor staff availability.

XIV. DATA CENTER COMPENSATING CONTROLS

In those situations where a standard system maintainer releases source code to its data centers, those data centers are expected to establish management controls over Medicare production code and to exert strict controls over local code that must be used to augment core standard system source code. Program Memorandum, Transmittal AB-01-80, Change Request 1625, issued May 15, 2001, outlines the controls that must be adhered to with respect to the management of production code at all locations, as well as the management of source code as long as it must be distributed.

XV. CONTRACTOR STANDARD SYSTEMS TRANSITIONS

Migration to the selected Part B standard system will continue into FY 2005.

XVI. DATA CENTER COSTS

Contractors are required to provide the projected annual data center costs in their budget request and actual data center costs on the IER and FACP. This cost consists of the charge from the data center to the contractor to support its processing of the standard system (FISS, MCS, VMS-D, VMS-B) that you use. This would include such items as: the production and testing costs, backups, special runs, hot site testing, and financial and claims processing sub-systems, such as the Regulations Tracking System (RTS), the Debt Collection System, and the Provider Statistical & Reimbursement Report (PS&R) that are integral to processing of claims. It should not include any front end processing that collects claims from providers or any back end functions such as print mail costs.

Report the total amount, not the cost per claim. Note that this should only include the cost of running the standard system, not the entire ADP costs for all Medicare related work. This information should be reported for each data center that a contractor uses. This information should be reported whether you use your own or someone else's data center. Miscellaneous Codes have been assigned in CAFM II for each Data Center. Contractors using a CMS supplied data center (MCDC 1 or MCDC2) do not have to report this cost information since CMS contracts directly for these services.

The costs reported should include processing costs and scheduling and support costs. The following is a description of what these costs should include:

Processing costs include the charges billed or the costs allocated to the contractor in compensation for the consumption of data center resources such as CPU, DASD, tapes, software, labor, facilities, overhead costs, etc.

Scheduling and support costs include the charges billed or costs allocated to the contractor in compensation for the maintenance and operation of the standard system at the data center. These activities normally are for the labor to maintain the standard system at the data center and install any updates at the data center, to submit and monitor jobs that run at the data center and any special programming that is performed for the contractor associated with standard system functions.

Do not include charges or costs associated with any front end or back end functions such as claims collection at the contractors site, print mail functions, or accounting reconciliation functions.

Enter the total costs for the data center using the following Miscellaneous Codes in CAFM II.

Misc. Code	Data Center
51020/01	AdminaStar Federal Inc.
51020/02	(inactive)
51020/03	BCBS Alabama
51020/04	BCBS Arkansas
51020/05	BCBS Kansas
51020/06	CIGNA
51020/07	EDS - Plano
51020/08	EDS - Sacramento
51020/09	Empire BCBS
51020/10	First Coast Service Options
51020/11	(inactive)
51020/12	GTE Data Services
51020/13	Highmark
51020/14	Mutual of Omaha
51020/15	Palmetto (aka BCBS South Carolina)
51020/16	Regence BCBS Oregon
51020/17	(inactive)
51020/18	(inactive)

XVII. USER FEES

CMS is proposing a number of FY 2005 user fees as a supplemental method of financing the agency's critical functions. Several of the proposed user fees would need to be implemented by intermediaries and carriers. They include:

- Charge providers a $50 filing fee for an appeal filed under CMS' new qualified independent review process.

- Charge providers who forward duplicate or unprocessable claims $5.00 per claim.

If Congress approves proposed legislation to authorize these fees, CMS will issue instructions to contractors on how to implement them. This is informational at this time. Do not include a request for funds in your FY 2005 Budget Request or take any actions to implement these fees until advised by CMS.

XVIII. CMS RETENTION BONUS POLICY STATEMENT

CMS' policy regarding the payment of retention bonuses paid to employees where the current contract/agreement is not renewed or is terminated was included in a letter to all contractors dated November 15, 2000. That letter clarifies CMS' policies and procedures regarding the transition and termination or non-renewal costs incurred by a contractor exiting the program and should be reviewed in its entirety.

XIX. CFO FINANCIAL MANAGEMENT ACTIVITIES

The Chief Financial Officers Act (CFO) of 1990 (Pub. Law 101-576) requires CMS to prepare annual, audited financial statements, reporting its financial position and results of operations.

During fiscal year (FY) 2002, CMS and the Office of the Inspector General (OIG) conducted a series of reviews including accounts receivable agreed-upon procedures reviews, reviews of CMS' referral and collection of debt under the Debt Collection Improvement Act of 1996, Statement on Auditing Standard (SAS) 70 audits, Certification Package of Internal Controls (CPIC) reviews, CMS-1522 reviews, and the annual CFO financial statements audit. In each of these initiatives, our contracted Certified Public Accounting (CPA) firms, as well as our CFO auditors, have noted marked improvement in Medicare contractors' financial reporting practices.

Despite these improvements, the auditors have identified continuing weaknesses in some Medicare contractors' performance and operations. The 2003 CFO audit and accounts receivable reviews continued to identify weaknesses in Medicare accounts receivable activity at the contractors reviewed. While some contractors performed their work appropriately, others were unable to support accounts receivable balances or could not reconcile their reported balances to subsidiary records. The auditors also continue to note weaknesses in Medicare electronic data processing controls.

For these reasons, CMS continues to require specific financial management activities for the FY 2005 BPRs. These activities include provisions requiring that each Medicare contractor designate an individual to serve full-time as its Chief Financial Officer for Medicare Operations, who will be responsible for developing and implementing approved Corrective Action Plans (CAPs) to correct deficiencies identified, ensuring the retention of supporting documentation, reconciling CMS financial reports, and performing trending analysis of financial data, especially in the area of accounts receivable.

CAFM II Miscellaneous Codes have been established to identify the cost of these activities. Contractors should continue to allocate the costs of theses activities to the functions, as you have in the past. Report the total costs of these CFO activities using the following Miscellaneous Codes:

a. Chief Financial Officer (CFO), Medicare Operations, should be reported using Miscellaneous Code 51010/01, including costs of activities incurred to support this position, i.e., portion of salaries of administrative/clerical staff dedicated to support the CFO;

b. Preparation, Reconciliation and Trending of Financial Reports and Correction of Deficiencies should be reported using Miscellaneous Code 51010/02.

CHIEF FINANCIAL OFFICER (CFO), MEDICARE OPERATIONS (Miscellaneous Code 51010/01).

Medicare contractors must establish a position of Chief Financial Officer, Medicare Operations, that is responsible for all Medicare financial reporting and internal controls and reports directly to the Vice President of Medicare Operations. We are not requiring that a separate, stand-alone Medicare financial unit be established. Our intent, however, is that the Medicare CFO position be responsible exclusively for Medicare financial operations and not have responsibility for other external third party or corporate activities. Any contractor, who wishes to deviate from this instruction, must contact Jeff Chaney, Acting Director, Accounting Management Group, Office of Financial Management at (410) 786-5412, or Gchaney@cms.hhs.gov. The qualification standards for this position must include knowledge of and extensive practical experience in financial management practices in large organizations and significant managerial or other practical involvement relating to financial management. The qualification standards also include an accounting degree from an accredited four-year college or possessing an active Certified Public Accountant (CPA) license, or meeting the eligibility requirements to sit for the CPA examination.

This position will be responsible for all Medicare financial operations including 1) developing control procedures to provide independent checks of the validity, accuracy, completeness and reconciliation of all financial data prior to being reported to CMS; 2) ensuring and certifying that appropriate Corrective Action Plans (CAPs) are prepared timely and implemented; 3) ensuring that the self-monitoring of internal controls include policies and procedures for prompt resolution of findings identified in Medicare-related audits and other reviews, 4) ensuring that the Provider Overpayment Report (POR) and the Physician/Supplier Overpayment Report (PSOR) are accurate, up-to-date, and reconciled to financial data reported to CMS, 5) validating that all outstanding accounts receivable are supported by appropriate source documents that will be able to withstand independent audit review, and 6) ensuring that trending analysis is performed on accounts receivable and other financial data reported to CMS.

The CFO for Medicare Operations will be responsible for: certifying the accuracy and completeness of all Medicare-related financial reports including the CMS-750, CMS-751, CMS-1521, CMS-1522, CMS-1523, CMS-1524, and the CMS-456; that timely reconciliations of financial reports and trending analysis of financial data are performed; and that an effective internal control structure over Medicare financial management operations are in place and operating effectively.

The CFO for Medicare Operations is also responsible for providing CMS' Office of Financial Management with quarterly reports which provide the status of the contractor's CAP implementation for all financial management related deficiencies resulting from CFO audits, SAS-70 internal control reviews, accounts receivable reviews, CPIC reviews, CMS-1522 reviews, as well as other financial audits and reviews performed by CPA firms, the Office of Inspector General (OIG), and the General Accounting Office (GAO).

The CFO for Medicare Operations will be expected to represent your organization at CMS-sponsored CFO conferences and meetings.

PREPARATION, RECONCILIATION AND TRENDING OF FINANCIAL FORMS, AND CORRECTION OF DEFICIENCIES (Miscellaneous Code 51010/02).

The lack of an integrated general ledger at the Medicare contractors underscores the need to correctly record, classify, and report accounting transactions, maintain supporting documentation, independently review and validate financial data, and reconcile financial data to detailed subsidiary reports and supporting documentation. Contractors' internal control structure must provide for documents and records that are adequate to ensure proper recording. Supporting documentation must be available upon request that support data reported on all financial reports. The Medicare contractor will record all staff time spent on the preparation and reconciliation of Forms CMS-1521, CMS-1522, CMS-456, CMS-750, and CMS-751, in accordance with CMS' Medicare Manual System, Pub. 100-6, Financial Management, Chapter 5, Section 210, Instructions for Completing Form CMS-750 A/B, Contractor Financial Reports, and Section 240, Instructions for Completing Form CMS-751 A/B, Status of Accounts Receivable.

With accelerated reporting requirements imposed by the Office of Management and Budget (OMB) that are effective, beginning in FY 2004, CMS is required to accelerate the preparation of its financial statements. To meet this requirement, Medicare contractors will be required to submit for the quarters ending June 30 and September 30, respectively, the Form CMS-751 reports and the corresponding accounts receivable section of the Form CMS-750 reports in an accelerated time frame.

Since April 1998, CMS' CFO requires Medicare contractors to perform a monthly reconciliation of paid claims submitted by providers to the total funds expended reported on the form CMS-1522. The monthly reconciliation is an important control and must be forwarded to CMS by the 15th of each month.

To determine that accounts receivable balances reported on Forms CMS-750 and CMS-751 are reasonable prior to being reported to CMS, Medicare contractors are required to perform trend analysis procedures. Trend analysis is an important tool to identify potential errors, system weaknesses, or inappropriate patterns of accounts receivable accumulation, collections, transfers or write-offs. Trending analysis involves comparisons of recorded amounts to expectations developed by the Medicare contractor, and can detect abnormal variations from period to period and identify unusual items that must be investigated and, if necessary, corrected. Medicare contractors must prepare and submit a summary memorandum explaining any unusual variances which must be reviewed and certified by the CFO for Medicare Operations. Work papers along with other documentation supporting the trending analysis performed must be made available to CMS and auditors upon request.

Additionally, the Medicare contractor will record all staff time spent on the development and implementation of approved CAPs for all financial management related deficiencies resulting from CFO audits, SAS-70 internal control reviews, accounts receivable reveiws, CPIC reviews, CMS-1522 reviews, as well as other financial audits and reviews performed by CPA firms, the OIG, and the GAO. Upon completion of any of these types of reviews, the Medicare contractor will receive a final report from the auditors or consultants, noting all findings. Within 45 days of

receiving the report, contractors are required to submit an initial CAP report that addresses all of the reported findings and is certified by the Vice President of Medicare Operations.

The CAP must include a detailed description of each finding, detailed corrective steps or procedures to be taken to correct the finding, responsible individuals, as well as target and actual completion dates. The CAP should also clarify new or revised procedures for detection and prevention controls that will be implemented to prevent similar types of deficiencies from occurring in the future. The Medicare contractor must also continue to submit a quarterly updated CAP report, even if all findings are considered closed by the Medicare contractor until CMS has notified you that you are no longer required to submit one.

XX. FINANCIAL INFORMATION SURVEY ADDENDUM

The Financial Information Survey can be found in Section 230 of the Medicare Financial Management Manual and should be submitted as an integral part of the BR. Include your response and any related supporting documentation as part of your Budget Request.

XXI. DATA CENTER SUPPORT FOR SINGLE COPY LOAD

During FY 2005, data centers running the Fiscal Intermediary Standard System (FISS) will be expected to provide support for single copy load, which is the CMS sponsored project for the removal of source code from the data centers and replacing it with only executable modules. This project will require the data centers to actively participate in the batch standardization processes and the review of current local code modifications in workgroups with the maintainer, users and CMS to determine the need for future deployment into the FISS. In addition, data centers will be required to test the systems changes made to support the single copy load project.

XXII. EXPANDED IDENTIFICATION AND WORKLOAD REPORTING FOR CMS SYSTEMS (CHANGE REQUEST 3256)

Intermediaries and Rural Home Health Intermediaries (RHHI) shall assign all providers they service to a state associated workload via a new “business segment identifier (BSI)” on the provider file. The contractor shall maintain claims administration files with the BSI and submit CROWD workload and management reports at the state associated BSI level for intermediaries and a separate set of reports for RHHI workload.